HCFA MEDICARE • MEDICAID Health Care Financing Administration

Volume IV, Number 6 February 1999

HEALTH watch

HCFA Wins with Welfare-to-Work Initiative

President Clinton directed all federal agencies to develop plans to hire current welfare recipients into available jobs on March 8, 1997. Under the directive, the Health Care Financing Administration allocated 15 slots to hire welfare recipients nationwide in its Career Start Program. We recruited nine participants in Baltimore's Headquarters and five in our regional offices.

Career Start provides individuals with the opportunity to acquire good work habits and to attain marketable work skills. Using an individual development plan, employees outline on-the-job developmental assignments and formal training needs. In addition to an initial orientation process, Career Start participants received instruction in "Coping With Workplace Transitions," "Effective Time Management," and other pertinent topics. Career Start participants were also assigned mentors who served as reference resources and helped to make the transition to the workplace as smooth as possible. Participants had the support of HCFA's Employee Assistance Program (EAP). During the first year of the program, participants attended biweekly group meetings with an EAP counselor also to assure a smooth transition to the workplace.

Once the Career Start participants satisfactorily complete three years of service, they will become permanent employees of the agency. Satisfactory performance includes completing requisite training and meeting qualification requirements for the occupation in which they are serving. In the interim, participants are encouraged to pass the Office of Personnel Management's Clerical Test.

Tina Grimm is an example of the success of the program. She expresses gratitude for this opportunity to enter the professional workforce. As a result of a stable work environment and positive reinforcement by her supervisor and mentor, as well as personal accomplishments, she continues to be motivated. In that respect, her supervisor continues to provide her with the opportunity to meet new challenges by providing support for higher education. She is confident that putting forth her best effort will ensure establishing a rewarding career for herself. ◆

Career and organization development specialists Harold Shaffer and Mavis Russell contributed this article.

Y2K "How-to" Materials to Assist Health Care Providers and Suppliers

The Health Care Financing Administration recently announced that it is making available new support materials to help hospitals, physicians and other Medicare partners achieve Year 2000 computer compliance. The new materials, available at www.hcfa.gov/Y2K, include how-to steps that can be taken by a Medicare provider or supplier to become Y2K ready.

"We are committed to doing our part to be sure that Medicare beneficiaries receive the care they need and that providers are properly paid," HCFA Administrator Nancy-Ann Min DeParle said. "As of today, we have completed the renovation, testing and validation of all of HCFA's mission-critical internal systems, and have made significant progress with our carriers and intermediaries. Now we are providing tools for individual health care providers and suppliers to assist them

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IMPORTANT ACTIONS

— **INVENTORY** hardware and software programs and **IDENTIFY** everything that is mission-critical to business operations.

— **ASSESS** the readiness of everything on the list. Providers will need to **CONTACT** hardware and software vendors, maintenance and service contractors, state professional and business associations, and **ACCESS** key information from various web sites to **DETERMINE** readiness as well as options for systems upgrade or replacement.

— **UPDATE** or **REPLACE** systems and software programs that are important to business operations.

— **TEST** existing and newly purchased systems and software. Providers will need to **CONTACT** vendors, billing services, banks and managed care organizations or private insurance companies necessary to **TEST** interfaces.

— **DEVELOP** business contingency plans in case of unexpected problems. Providers and suppliers will need to **FOCUS** on things which would be most problematic.

HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

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Have you met your requirements for millennium compliance?

Message from the Administrator

NANCY-ANN MIN DEPARLE

MEDICARE REMAINS strongly committed to allowing beneficiaries to choose to receive their benefits through the widest range of health care options possible.

Before the bipartisan Balanced Budget Act of 1997 (BBA), most beneficiaries could choose only between original Medicare, with or without a supplement, and Medicare HMOs, if available in their communities. Each month, about 60,000 to 70,000 beneficiaries enroll in Medicare managed-care plans.

The BBA created Medicare+Choice, which expanded the types of private health plans that can participate in Medicare. In January, we approved the first of these new types of plans — St. Joseph Healthcare, a provider-sponsored organization that will serve four counties in New Mexico.

Over time, we expect that more beneficiaries will have access to Medicare+Choice plans. And plans should be paid fairly. That's why Medicare will begin using a new BBA-required payment method, known as risk adjustment, that more accurately reflects the costs of providing care.

To ensure a careful, balanced approach, HCFA is phasing in the change. We will closely monitor its impact on both beneficiaries and plans.

Under risk adjustment, Medicare for the first time will base Medicare payments to plans on the health status of the beneficiaries that they enroll. This ensures that health plans get paid more money for enrolling the sickest beneficiaries, who are likely to require the most care. Under the old law, Medicare paid plans a fixed rate, adjusted only for demographics, regardless of the health status of each enrolled beneficiary.

Risk adjustment looks at each beneficiary's diagnosis in one year to predict how much, if any, additional cost there would be for the next year. For example, if a beneficiary had a stroke, the plan would receive a larger payment in the following year to cover the expected additional costs. A plan would not receive additional payment for a beneficiary who had appendicitis, which would not be expected to lead to higher-than-average costs in the following year.

Risk adjustment also will ensure that Medicare does not overpay plans that tend to enroll healthier-than-average beneficiaries. The Physician Payment Review Commission, now called MedPAC, estimated in a 1997 Report to Congress that Medicare overpaid plans by up to $2 billion a year.

We will begin risk-adjusted payments to Medicare+Choice plans on January 1, 2000, as the law requires. While not required by law, we will phase in the adjustments over five years to ensure that plans have time to adjust to the changes. In the first year, only 10 percent of a plan's payment for each beneficiary will be calculated based on risk adjustment, while the remaining 90 percent would be based on the current system. Each year, the ratio will shift until 2004, when Medicare will pay plans entirely under risk adjustment.

We are moving cautiously to ensure a stable marketplace to protect Medicare beneficiaries who choose managed care. We decided to phase in the changes to ease their transition.

I'm confident that risk adjustment will strengthen the Medicare+Choice program and create a more stable marketplace for the more than 6 million beneficiaries who are now enrolled in Medicare+Choice plans.◆

Medicare+Choice Contractor

HMO Plan Offered to Medicare Beneficiaries in Nine West Virginia Counties and Seven Ohio Counties

The Health Care Financing Administration (HCFA) approved the Health Plan of Upper Ohio Valley in December 1998 to offer managed care coverage as a Medicare+Choice contractor to Medicare beneficiaries in nine West Virginia counties and seven Ohio counties, effective on Feb. 1, 1999.

The plan currently offers managed care coverage to Medicare beneficiaries in six counties in West Virginia and six counties in Ohio under a cost contract. HCFA reimburses the managed care organization (MCO) for actual expenses rather than providing the MCO with a monthly capitation payment.

Health Plan of Upper Ohio Valley, based in St. Clairesville, Ohio, is one of seven applications that will begin serving Medicare beneficiaries in Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum and Noble counties in Ohio, as well as Brooke, Hancock, Harrison, Marion, Marshall, Monongalia, Ohio, Tyler and Wetzel counties in West Virginia. About 115,500 eligible Medicare beneficiaries live in the MCO's service area.

Currently, about 6.5 million Medicare beneficiaries, out of a total of 38 million aged and disabled Americans, have enrolled in Medicare HMOs. HCFA, which oversees the Medicare program, has an additional 43 applications from managed care plans seeking to serve beneficiaries in either new or expanded service areas.

Managed care and other new health care options, known as Medicare+Choice, are available where private companies choose to offer them. Original fee-for-service Medicare, currently chosen by about 32 million of Medicare's 38 million beneficiaries, is available to all beneficiaries.

Congress created Medicare+Choice in the Balanced Budget Act of 1997 to expand the types of health care options available to Medicare beneficiaries. As part of Medicare+Choice, Medicare now offers new preventive benefits and patient protections, as well as a far-reaching information program that includes a national toll-free phone number at 1-800-318-2596, a new Internet site at www.medicare.gov, and a coalition of more than 200 national and local organizations to provide seniors with more information.◆

Selected Health Issues on the Web

http://www.hcfa.gov/hipaa/hiwhfaq.htm

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On Oct. 21, 1998 the Women's Health Cancer Rights Act of 1998 was signed into law. The law provides important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. General guidance and frequently asked questions on the new law are provided.

http://www.rx2000.org/

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HEALTH CARE'S YEAR 2000 INFORMATION CLEARINGHOUSE

This non-profit web site for medical providers contains a useful survey and an open invitation for visitors to join. The Federal Drug Administration warns hospitals, emergency medical services and health care practitioners that computer date bugs expected to produce problems on Jan. 1, 2000, will affect some medical devices a year early.

http://www.census.gov/ipc/prod/ib98-2.pdf

GENDER AND AGING: MORTALITY AND HEALTH

The October issue of *Gender and Aging: Mortality and Health* by the U.S. Census Bureau outlines the health care challenges inherent in worldwide life expectancy gains. According to the study, women who reach older age can expect to live more disability-free years than their male counterparts and the number of widows is rising rapidly in most parts of the world. This magazine is available through the Adobe Acrobat Reader on the Internet free of charge.

http://wonder.cdc.gov

CDC WONDER

This site provides a single point of access to a variety of Centers for Disease Control and Prevention (CDC) reports, guidelines, and numeric public health data. CDC WONDER furthers CDC's mission of health promotion and disease prevention by speeding and simplifying access to public health information for state and local health departments, the Public Health Service, the academic public health community, and the public at large. CDC WONDER can be valuable in public health research, decision-making, priority-setting, program evaluation, and resource allocation.◆

Estimated 2.8 Million Children to Benefit from 49 CHIP-Approved Plans

The Children's Health Insurance Program (CHIP) provides states and U.S. territories $24 billion to pay for health insurance coverage over a five-year period. In the first year of CHIP, $4.3 billion was set aside to help expand health insurance coverage to children whose families earn too much for traditional Medicaid, yet not enough to afford private health insurance.

CHIP regulations allow states three options in devising a plan before the Department of Health and Human Services reviews and approves it. The following table shows the options.

PLAN OPTIONS FOR STATES	
✓ design	new health insurance program
✓ expand	current Medicaid programs, or
✓ combine	both of the above

CHIP plans have been approved in 49 states and U.S. territories. In order of their approval, they are: Alabama, Colorado, South Carolina, Florida, Ohio, California, Illinois, New York, Michigan, Missouri, New Jersey, Connecticut, Rhode Island, Oklahoma, Pennsylvania, Massachusetts, Wisconsin, Oregon, Texas, Idaho, Puerto Rico, Indiana, Utah, North Carolina, Minnesota, Maryland, Arkansas, Nebraska, Maine, Nevada, South Dakota, Iowa, Kansas, Delaware, Georgia, Montana, New Hampshire, West Virginia, Virgin Islands, the District of Columbia, Arizona, North Dakota, Louisiana, Virginia, Mississippi, Kentucky, Alaska, Vermont and New Mexico.

HCFA is currently reviewing plans from Tennessee, Hawaii and Guam.◆

Funding by State or Territory	Estimated Number of Children	Eligibility (Based on 1998's $16,450 annual income for a family of four according to Federal Poverty Level [FPL] guidelines.) All states with CHIP plans will receive federal matching funds only for actual expenditures on insuring children.
New Mexico $57M	5,000 by Sept. 2000	New Mexico will use its federal allotment to expand its existing Medicaid program to cover children up to age 18 in families with incomes up to 235 percent of the federal poverty level ($38,657.50). The benefit package will be the same as the state's Medicaid program benefit plan. Families with incomes between 186-235 percent of poverty ($30,587 and $38,657.50) will be charged nominal copayments of $5 per visit to the doctor. However, cost-sharing cannot exceed 5 percent of a family's annual income.
Vermont $3.5M	1,000 by Oct. 2000	Vermont will use its federal allotment to create a new state health insurance program to cover children up to age 18 in families with incomes between 225 and 300 percent of the federal poverty level ($37,012.50 and $49,350). Vermont's Medicaid program currently covers uninsured children up to 225 percent of poverty ($37,012). The benefit package will be the same as the state's Medicaid program benefit plan. The state will charge qualified families a premium of $10 per month per household. The state plans to raise that amount to $20 per month per household at a later date. Beginning July 1, 1999, providers will also be allowed to charge a $10 copayment for office visits. However, cost-sharing cannot exceed 5 percent of a family's annual income. ◆

Calendar of Events

Feb. 19 — Administrator Nancy-Ann Min DeParle addresses the National Congress of American Indians in Washington, D.C., on *Relevant Legislative Initiatives and Budgetary Issues That Affect Federal Indian Policies.*

Feb. 23 — Administrator DeParle speaks at the American Association of Health Plans in Washington, D.C., on *The Implementation Challenges of the Medicare+Choice Program and the BBA Provisions Affecting State Medicaid Managed Care Programs.*

Feb. 24 — Administrator DeParle addresses the AARP in New York City on *Who Pays? You Pay* via satellite.

March (date to be determined) — Deputy Administrator Michael Hash speaks at the Hepatitis B Kick-off Event in Boston, Mass.

March 5 — Administrator DeParle addresses the Center for Corporate Innovation in Philadelphia, Pa. on *Medicare/Medicaid.*

March 25 — Administrator DeParle speaks at the California Association of Health Plans in Palm Springs, Calif., on *The Future of Medicare.*

New Regulations/Notices

Medicare Program; Schedules of Per-Visit and Per-Beneficiary Limitations on Home Health Agency Costs for Cost Reporting Periods Beginning on or After October 1, 1998; Correction [HCFA-1035-CN] — Published 10/28. This document corrected technical and typographical errors in the August 11, 1998 *Federal Register* (63 FR 42912) notice that set forth revised schedules of limitations on home health agency costs that may be paid under the Medicare program for cost reporting periods beginning on or after October 1, 1998. The effective date of this correction notice was October 1, 1998.

Medicare Program; Request for Nominations for the Practicing Physicians Advisory Council [HCFA-1048-N] — Published 11/10. This notice requested nominations from medical organizations representing physicians for individuals to serve on the Practicing Physicians Advisory Council (the Council). The Council advises the Secretary of the Department of Health and Human Services on proposed regulations and manual issuances related to physicians' services. Four Council members' terms of service are scheduled to expire on February 28, 1999. Nominations received no later than 5 p.m. on November 30, 1998, were considered.

Medicare Program; Hospice Wage Index; Corrections [HCFA-1039-CN] — Published 11/12. This notice corrected errors made in the October 5, 1998 *Federal Register* (63 FR 53446) notice announcing the annual update to the annual hospital wage index. The wage index is used to reflect local differences in wage levels. The updated wage index was effective October 1998, the second year of a three-year transition period.

Medicare Program; Prospective Payment System for Hospital Outpatient Services; Extension of Comment Period [HCFA-1005-N] — Published 11/13. This notice extended the comment period for a proposed rule published in the September 8, 1998 *Federal Register*, (63 FR 47552). In that rule, as required by sections 4521, 4522, and 4523, of the Balanced Budget Act of 1997, HCFA proposed to eliminate the formula-driven overpayment for certain outpatient hospital services, extend reductions in payment for costs of hospital outpatient services, and establish in regulations a prospective payment system for hospital outpatient services (and for Medicare Part B services furnished to inpatients who have no Part A coverage).

Medicare Program; Update of Ratesetting Methodology, Payment Rates, Payment Policies, and the List of Covered Procedures for Ambulatory Surgical Centers Effective October 1, 1998; Extension of Comment Period [HCFA-1885-3N] — Published 11/13. This notice extended the comment period to January 8, 1999 for a proposed rule published on June 12, 1998 in the *Federal Register* (63 FR 32290) which made various changes, including changes to the ambulatory surgical center (ASC) payment methodology and the list of Medicare covered procedures.

Medicare Program; Limited Additional Opportunity to Request Certain Hospital Wage Data Revisions for FY 1999 [HCFA-1049-FC] — Published 11/19. This final rule with comment period provided hospitals with the opportunity to request certain revisions to their wage data used to calculate the FY1999 hospital wage index. In addition, it explained the criteria that must be used to request a revision, the types of revisions that would be considered, the procedures for requesting a revision, the implementation of wage index revisions, and other related issues. Requests for wage data revisions were to be received by the date and time specified by the "DATES" section of this preamble. HCFA implemented revisions to the hospital wage index in accordance with this final rule with comment period on a prospective basis only. Comments received by 5 p.m. on December 21, 1998, were considered.

Medicare Program; Inpatient Psychiatric Services Benefit for Individuals Under Age 21 [HCFA-2060-F] — Published 11/19. This final rule amends the CFR by adding a choice of accreditation organizations that a state Medicaid agency may use to fulfill the requirement for Medicaid approval of, and payment to, psychiatric facilities other than psychiatric hospitals or psychiatric units of acute care hospitals that provide the "inpatient psychiatric services benefit for individuals under 21." In response to comments received on a prior comment proposed rule, HCFA is retaining the requirement for accreditation of psychiatric facilities, but HCFA is offering alternatives to accreditation by the Joint Commission on Accreditation of Health Care Organizations. Accreditation of psychiatric facilities, other than psychiatric hospitals and psychiatric units in acute care hospitals, could be performed by the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting body with comparable standards that are recognized by the state. This change is being made while HCFA continues to develop its standards for psychiatric facilities based on its evaluation of the comments that HCFA received on the proposed standards that were published in the Notice Of Proposed Rule Making. All of the comments on the remaining provisions of the proposed rule will be addressed in a second final rule to be published at a future date. This rule became effective on December 21, 1998.

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Reopening of Comment Period [HCFA-1013-N2] —Published 11/27. HCFA published an interim final rule with comment period in the May 12, 1998 *Federal Register* (63 FR 26252) to implement provisions in section 4432 of the Balanced Budget Act of 1997 related to Medicare payment for skilled nursing facility services. These include the implementation of a Medicare prospective payment system for skilled nursing facilities, consolidated billing, and a number of related changes. A document published on July 13, 1998 extended the comment period for the May 12, 1998 interim final rule until September 11, 1998. This document reopened and extended the comment period to 5 p.m. on December 28, 1998. This document also clarifies the explanation of the federal rates.

Medicare Program; Recognition of the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., for Ambulatory Surgical Centers Program [HCFA-2008-FN] — Published 12/2. This notice announces the approval of the American Association for the Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) as an accreditation organization acknowledged by the Medicare program. HCFA has found that AAAASF's standards for ambulatory surgical centers (ASCs) meet or exceed those established by the Medicare program. ASCs accredited by AAAASF will receive deemed status under the Medicare program. This final notice is effective from December 2, 1998 through December 2, 2004.

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Regulations/Notices, from page 5

Medicare Program; Recognition of NAIC Model Standards for Regulation of Medicare Supplemental Insurance [HCFA-2025-N] —Published 12/4. This notice describes changes made by the Balanced Budget Act of 1997 to section 1882 of the Social Security Act, which governs Medicare supplemental insurance. It also recognizes that the Model Regulation adopted by the National Association of Insurance Commissioners (NAIC) on April 29, 1998, as corrected and clarified by HCFA, is considered to be the applicable NAIC Model Regulation for purposes of section 1882 of the Social Security Act. The changes made by HCFA (1) correct a drafting error in section 12.B(2) of the Model that is inconsistent with federal law, and (2) add a clarification that copayments for hospital outpatient department services under Part B of Medicare must be covered under the "core benefits" of a Medicare supplemental insurance policy in the same manner as coinsurance for those services. Finally, this notice prints as an addendum the full text of the NAIC Model Regulation, as corrected and clarified by HCFA. Medicare supplemental insurance policies issued in any state must conform to the requirements of section 1882(s)(3) of the Social Security Act as of July 1, 1998, and to the standards contained in the revised NAIC Model Regulation as of the date the state adopts the revised standards, which generally must be no later than April 29, 1998.

Medicare Program; Criteria and Standards for Evaluating Intermediary and Carrier Performance; Millennium Compliance [HCFA-4002-GNC] — Published 12/11. This notice revises the criteria and standards to be used for evaluating the performance of fiscal intermediaries and carriers in the administration of the Medicare program. This revision establishes a performance standard requiring these contractors to meet requirements for millennium compliance. HCFA requires contractors to certify that they have made all necessary system(s) changes and have tested those systems in accordance with HCFA guidelines. Effective date of this notice was December 11, 1998. ◆

Y2K, from page 1

in addressing their Y2K requirements. They must take timely action to ensure that their claims will reach us successfully, so that we in turn can continue to provide proper compensation."

Y2K conversion is critical to smooth processing of health care claims for the 38 million Medicare beneficiaries. It requires identifying, renovating and testing computer and information systems to assure accurate processing of date fields on and after January 1, 2000.

HCFA and other federal agencies have been working with national organizations representing health providers and suppliers across the United States, including doctors, hospitals and pharmaceutical and health equipment manufacturers to help them make sure their computer systems will be Year 2000 ready. HCFA has developed interconnecting software programs for providers and is sharing requirements and guidance to help them bill Medicare in a Y2K-compliant manner.

"As we certify our own systems and those of our contractors who pay Medicare claims, we are reaching out with information and guidance to help our partners in the private sector achieve Y2K compliance," DeParle said. "They must take action themselves so every Medicare provider will be protected. The Medicare program will be ready — and individual providers must be ready, too." ◆

The full text of the Administrator's letter on Y2K issues can be found at:

www.hcfa.gov/y2k/pl011299.htm

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✔✔✔ HCFA Outreach to Health Care Partners on Y2K ✔✔✔

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Y2K

The Health Care Financing Administration (HCFA) recently sent a letter to over a million of its health care partners and provider-related associations regarding Y2K. The message is that HCFA will be ready to process and pay all acceptable claims by January 1, 2000 and that providers must take steps to ensure their own readiness in order to be paid promptly. Further, the Y2K problem has implications for patient care. Providers should take steps to assure that beneficiaries continue to receive the same quality of care. The letter included a checklist that providers could use as a tool to assess their Y2K readiness. We are making this convenient pullout checklist available to you to help determine your Y2K readiness. Please recognize that this information is not intended to be all inclusive.

The letter to health care partners is part of an extensive outreach effort being conducted by HCFA to promote Y2K readiness among all providers engaged in delivering health care services to Medicare beneficiaries. In addition to this letter and the resource information on HCFA's web site, www.hcfa.gov, HCFA can make speakers available to health care provider organizations that wish more detailed information about Y2K readiness and the implications of the millennium change for the industry.

Sample Provider Y2K Readiness Checklist

Bank debit/credit card expiration dates	☐	Y2K Ready	☐	Not Y2K Ready
Banking interface	☐	Y2K Ready	☐	Not Y2K Ready
Building access cards	☐	Y2K Ready	☐	Not Y2K Ready
Claim forms and other forms	☐	Y2K Ready	☐	Not Y2K Ready
Clocks	☐	Y2K Ready	☐	Not Y2K Ready
Computer hardware (list)	☐	Y2K Ready	☐	Not Y2K Ready
Computer software (list)	☐	Y2K Ready	☐	Not Y2K Ready
Custom applications (list)	☐	Y2K Ready	☐	Not Y2K Ready
Diagnostic equipment (list)	☐	Y2K Ready	☐	Not Y2K Ready
Elevators	☐	Y2K Ready	☐	Not Y2K Ready
Fire alarm	☐	Y2K Ready	☐	Not Y2K Ready
Insurance/pharmacy coverage dates	☐	Y2K Ready	☐	Not Y2K Ready
Membership cards	☐	Y2K Ready	☐	Not Y2K Ready
Medical devices (list)	☐	Y2K Ready	☐	Not Y2K Ready

Monitoring equipment (list)	☐ Y2K Ready	☐ Not Y2K Ready
Safety vaults	☐ Y2K Ready	☐ Not Y2K Ready
Smoke alarm	☐ Y2K Ready	☐ Not Y2K Ready
Spreadsheets	☐ Y2K Ready	☐ Not Y2K Ready
Telephone system	☐ Y2K Ready	☐ Not Y2K Ready
Treatment equipment (list)	☐ Y2K Ready	☐ Not Y2K Ready

The Health Care Financing Administration will not assume any responsibility for your Y2K compliance.